DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0017	A. BUILDING: _____ B. WING _____	R-C 09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR	900 W 46TH ST DAVENPORT, IA 52806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 4 Number of tenants with cognitive disorder: 23 Total Population of Program at time of on-site: 27 TOTAL census of Assisted Living Program: 27 A second revisit of the investigation of Incident #64658-I was completed. Previously cited regulatory insufficincies were determinted to not be corrected, and were re-cited. During the course of the revisit, the investigation of 68237-I, 70048-I, and 70171-C were also investigated. The investigation of Incident #68237-I resulted in no regulatory insufficiencies cited. The investigation of Incident #70048-I and Complaint #70171-C resulted in regulatory insufficiencies..	{A 000}	See attached POC 10/28/17	
{A 007}	481-67.2(1)d Program Policies and Procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents	{A 007}		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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{A 007}	Continued From page 1 including allegations of dependent adult abuse. 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: d. The incident report shall include statements from individuals, if any, who witnessed the incident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure completion of incident reports for all incidents as required. This pertained to 2 of 6 tenants reviewed (Tenants #7 and #8). Findings follow: 1. Record review of Tenant #7's file revealed diagnoses included: dementia, bi-polar and depression. Tenant #7 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Review of Tenant #7's nurses notes revealed the following: a. On 6-7-17 an incident of sexual behavior towards another tenant was documented. Tenant #7 had his/her hands inside another tenant's protective undergarments. The other tenant was removed and Tenant #7 taken to the bathroom. The documented noted Tenant #7's behavior becoming more frequent. b. On 8-4-17 at 9:30 a.m. an incident of sexual behavior, in which Tenant #7 touched himself/herself in front of another tenant. Staff removed Tenant #7 from the area.	{A 007}		

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{A 007}	Continued From page 2 c. On 8-4-17 at 10:30 a.m. there was another incident of sexual behavior towards another tenant, in which Tenant #7 had his/her hands inside another tenant's pants. The other tenant was removed from the area and Tenant #7 was told his/her actions were inappropriate. Tenant #7 became very angry and combative. An ambulance was called and Tenant #7 refused to go with paramedics. Permission was given by the legal representative to have Tenant #7 sedated. Tenant #7 was transferred to the hospital and returned on 8-4-17. d. On 8-12-17 Tenant #7 acted out sexually towards another tenant. The other tenant left the area and Tenant #7 became aggressive towards staff. Tenant #7 stated he/she would break the staff's arm and chased staff down the hall yelling profanities at staff who escaped out the door. e. On 8-19-17 Tenant #7 became angry with the nurse when she removed tenants of the opposite sex from the living area. Tenant #7 became combative and tried to hit and push the nurse to the floor. The nurse left the building and as needed medication was administered. Further record review revealed a lack of completed incident reports for any of the incidents of sexual behavior or combative behavior for Tenant #7. According to the Program's policy and procedure regarding incident reports, an incident was any happening out of the ordinary such as a fall, illness or a change in behavior. All incidents were to be handled to provide for the well-being of the tenant. Only supervisors or department managers completed incident reports. Part of the	{A 007}		

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{A 007}	Continued From page 3 investigation should be to interview any caregivers and/or witnesses that had relevant information. Incident reports should be fully completed and should include: how, when and where the incident occurred, the nature of the injury, what was done for the tenant and date/time of the notification of the responsible party. Incident reports needed to be completed for all falls, any incident that resulted in injury or death, any elopement and verified medication error. Reports needed to be completed for witnessed and un-witnessed incidents. When interviewed on 8-23-17 at 8:50 a.m. the Executive Director confirmed incident reports were not found related to the behaviors regarding Tenant #7. Interviews with the Nurse on 8-21-17 at 3:04 p.m. and 8-22-17 at 4:15 p.m. revealed there no incident reports completed related to the behaviors with Tenant #7.	{A 007}		
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide adequate and appropriate care, treatment and services. This	A 013		

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A 013	Continued From page 4 affected 3 of 5 tenants reviewed (Tenants #5, #6 and #7). Findings follow: 1. Record review revealed incident reports completed by Staff A, on 8-9-17 at 6:30 p.m. Tenant #5 got out of his/her wheelchair and tried to walk. As the alarm went staff ran to grab him/her and Tenant #5 hit the floor before staff could catch him/her. Tenant #5 landed on his/her right leg and held his/her knee. Staff A further documented she and a co-worker got Tenant #5 back in his/her chair and to the dining room table. Staff A took his/her vitals (temperature was 97.3, respirations were 18, pulse was 65 and blood pressure was 144/85) and a pain medication was given. Tenant #5 began reading a book and calmed down. Staff checked the length of Tenant #5's legs and made sure his/her hip was in place, which it was. At that time he/she started saying he/she was in pain so staff took him/her to bed so that he/she could relax. About 10:30 p.m. his/her alarm went off. Tenant #5 was in pain and staff tried to elevate his/her legs but Tenant #5 did not want the pillow placed. Staff A went and got a co-worker because the way Tenant #5 was laying seemed strange. Tenant #5 screamed, "like in more pain." Staff waited for the Nurse to get there before assisting further to verify the position of the legs. When the Nurse arrived Staff A told her Tenant #5 should be sent out because he/she could not take the pain and Tenant #5 was sent out. According to the incident report, staff initially notified the nurse of the fall on 8-9-17 at 6:37 p.m. An incident reported completed by Staff B dated 8-9-17 indicated at about 6:40 p.m. Staff B responded to assist Staff A with lifting Tenant #5 from lying on the floor. Tenant #5 was able to sit in the wheelchair. At about 7:30 p.m. Staff A	A 013		

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A 013	Continued From page 5	A 013		

requested to put Tenant #5 in bed. Both of Tenant #5's legs were stretched out. At 11:06 p.m. Staff A told Staff B that Tenant #5 was in pain and his/her leg "bends."

Additional record review revealed Nurse's Notes, dated 8-17-17 (late entry), indicated staff called the Nurse on 8-9-17 at 6:30 p.m. and reported Tenant #5 fell to the floor in the living room. Staff was instructed to check for leg length and if the legs were even. Staff was to check range of motion and if there were any complaints of pain with movement. Tenant #5's family was called and said not to send to the emergency room (ER). Staff was instructed to stand Tenant #5 and to place in the wheelchair following hip precautions. Staff stated Tenant #5 transferred without incident or complaints of pain. Staff was instructed the Nurse would be in the building at 12:45 a.m. to work the night shift and to call if further complaints of pain. At 12:00 a.m. staff called the Nurse and stated Tenant #5 complained of pain and staff was instructed to give a pain pill and the Nurse was on her way to the program. At 12:45 a.m. the Nurse arrived at the building and assessed Tenant #5. The right leg was twisted under Tenant #5 and the left leg was pulled up to the chest. Staff was instructed to call an ambulance. Paramedics arrived and transferred Tenant #5 to the ER and Tenant #5's family was called again without success. At 2:00 a.m. a call was received from the hospital which indicated Tenant #5's femur was broken.

According to a PRN Medication Information document, the following was ordered: Hydrocodone/Acetaminophen 5/325 milligram (mg), one tablet, every four hours as needed for pain and Lorazepam 0.5 mg, one tablet, every four hours as needed for agitation. On 8-9-17 at

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6:30 p.m. one tablet of Lorazepam was administered and the result as of 7:30 p.m. was effective. On 8-9-17 at 6:40 p.m. one tablet of Hydrocodone/Acetaminophen was administered for pain and the result as of 7:20 p.m. was not effective. On 8-9-17 at 10:30 p.m. one tablet of Hydrocodone/Acetaminophen was administered for pain and the result as of 1:00 a.m. was not effective.

Emergency medical services records indicated the call was received on 8-10-17 at 12:53 a.m. and medics arrived at the building at 1:02 a.m. Medics were dispatched for a fall with hip pain. Staff reported Tenant #5 fell that afternoon on his/her hip. At that time Tenant #5 had not expressed any complaints and staff put Tenant #5 back into the wheelchair and later to bed. Staff reported after Tenant #5 was in bed he/she started having complaints of pain and they found him/her with a deformed right leg. It was noted Tenant #5 had an obvious deformity to the right hip and right leg and swelling to the same areas. The right leg was externally rotated and Tenant #5 had his/her leg bent at the knee. The left knee was drawn up and there were complaints of pain when that leg was straightened out. Tenant #5 was given Fentanyl intravenous push with improvement in his/her complaints of pain. Tenant #5 was transported to the hospital.

Hospital records indicated Tenant #5 was seen on 8-10-17 at 1:55 a.m. Records documented Tenant #5 sustained a fall the day prior while getting out of wheelchair, was to put to bed and woke up screaming with an obvious deformity to the right hip with shortening and rotation. Symptoms included: pain, swelling and loss of mobility and the degree at present was severe. Diagnostic Radiology records indicated the

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A 013	Continued From page 7 impression was an acute fracture of the right femoral diaphysis with displacement/angulation. The discharge summary indicated the date of admission was 8-10-17 to 8-16-17. Admission diagnosis included a right hip fracture. Discharge diagnosis indicated closed femur fracture, status/post open reduction and internal fixation of a closed periprosthetic femur fracture from a fall. Tenant #5 could not bear weight for eight weeks post surgery. The discharge summary indicated Tenant #5 was seated in a chair, tried to get up and suddenly fell. He/she was helped back to the chair but leg deformity was noted. Tenant #5 was brought to the hospital where Tenant #5 was diagnosed with a right hip fracture. Family decided to have surgical repair and Tenant #5 had an open reduction and internal fixation of the right femoral shaft fracture with bone grafting for the right periprosthetic closed femur fracture. Record review of Tenant #5's file revealed his/her diagnoses included: dementia, osteoporosis, degenerative joint disease and status/post compression fracture (thoracic). Tenant #5 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. The service plan reflected Tenant #5 had a chair alarm when in the chair and under him/her when in bed. Tenant #5 was independently mobile inside the building by propelling his/her wheelchair, but was dependent outside of the building. Tenant #5 had physical therapy (PT); however, it was discontinued on 8-9-17. Nurse's Notes dated 6-5-17 to 7-10-17 indicated Tenant #5 was admitted to the hospital for a broken hip. Tenant #5 underwent surgical repair of the hip, went to a skilled facility and returned to the Program on 7-10-17. An interview with Staff A on 8-21-17 at	A 013		

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A 013	Continued From page 8 approximately 2:25 p.m. revealed Tenant #5's family brought him/her to the living room and asked Staff A to let the family member out of the building. Staff A was going to get Staff B and Tenant #5's alarm went off and Staff A responded. Tenant #5 was lying on his/her right side in the living room. Staff A called the Nurse and Staff B stayed with Tenant #5. The Nurse instructed staff to check vital signs and to ensure Tenant #5's legs were even. Tenant #5 complained of knee pain and Staff A administered an as needed pain pill. There was nothing abnormal with vitals and Staff A and Staff B transferred Tenant #5 off the ground to the wheelchair. Tenant #5's family was notified and declined to send Tenant #5 out to the hospital. Once in the chair staff observed his/her legs and there were no other complaints voiced. Staff A and Staff B helped get Tenant #5 get dressed and ready for bed. Tenant #5 was relieved to lay down. The bed alarm would go off and Tenant #5 was close to the edge of the bed and was moved using the underpad. Staff A completed rounds and pulled back the covers and noticed the right leg looked funny and Tenant #5 grimaced. There was a dramatic change at 10:00 p.m./10:30 p.m. Staff A went and got Staff B as the leg did not look normal. The Nurse was called; she was coming in and directed them to give Tenant #5 another pain pill until she got there. Tenant #5 seemed like he/she was in pain. As soon as the Nurse arrived the non-emergency ambulance was called. An interview with Staff B on 8-21-17 at 4:44 p.m. Staff B cleaned up after supper and Tenant #5 was in the living room. Staff A was the caregiver for the area where Tenant #5 resided. Staff A had just come in the dining room and sat down and Tenant #5's chair alarm went off. Staff A got up and Tenant #5 was on the floor. Tenant #5's	A 013		

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A 013	Continued From page 9 family had just left. Tenant #5 was laying on the floor on his/her right side. There was no response when asked if there was any pain. Tenant #5 was picked up and put into the wheelchair. Staff A pushed Tenant #5 into the dining room and gave him/her a magazine. Tenant #5 could stand up when he/she was placed in the wheelchair and voiced no complaints of pain. Staff A and Staff B changed Tenant #5 into pajamas. Tenant #5 stood up when staff assisted Tenant #5 with getting changed for bed around 7:00 p.m. to 8:00 p.m. When Staff A and Staff B put Tenant #5 into bed his/her legs were straight. Close to 11:00 p.m. Tenant #5 was in pain and Staff A asked Staff B to look at Tenant #5's leg. It was different, the leg was bent in the opposite direction, it looked "like something out of the Exorcist." Tenant #5's leg was not like that before. As soon at the Nurse arrived she went in to check Tenant #5. Interviews with the Nurse on 8-21-17 at 3:04 p.m. and 8-22-17 at 4:15 p.m. revealed she worked on the floor the day of Tenant #5's fall. She received a telephone call from Staff A at 6:30 p.m. Staff A reported Tenant #5's family had just left and Staff A had gone into the other room and heard the chair alarm. Tenant #5 fell on his/her hip on the right side. There were no issues with shortening of legs and no complaints of pain. Staff B assisted Staff A with picking Tenant #5 up off the ground. Tenant #5 was weight bearing and had no complaints. Tenant #5 sat in the wheelchair in the dining room. Staff A and Staff B said Tenant #5's legs were straight. Something happened in bed and during rounds staff heard Tenant #5 moaning. Around 11:45 p.m. to 12:00 a.m. she received a telephone call from staff regarding Tenant #5 and she was on her way into the building. When the Nurse arrived Staff A asked	A 013		

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A 013	Continued From page 10 her to check Tenant #5's legs. Tenant #5's leg was twisted and a non-emergency ambulance was called. Tenant #5 was diagnosed with a femur fracture and needed surgery. A nurse at the hospital asked how Tenant #5 was left in that condition. The Nurse explained range of motion was completed and the leg was not deformed until 11:00 p.m. rounds. She was not informed the leg looked different until she arrived, staff had called the second time to administer a pain pill. A written statement from the Executive Director dated 8-10-17 indicated she arrived at the Program at 4:50 a.m. on 8-10-17 and received a report from the Nurse that Tenant #5 was sent to the hospital with a possible fracture. She called and spoke with Staff A, who reported Tenant #5 had been seated in the wheelchair and had spent time with his/her family in the living area. The family member had just left the building and Staff A walked into the dining room, a few feet from where Tenant #5 was located and she heard Tenant #5's chair alarm going off. Staff A ran towards Tenant #5, who was already falling to the floor. Staff A called the Nurse and gave a verbal report which indicated the fall occurred on the right side. Staff A verbalized Tenant #5's legs were even. There was no evidence of pain, other than Tenant #5's knee hurt a little bit. Staff A and Staff B assisted Tenant #5 back into the wheelchair and Staff A assisted Tenant #5 into the dining room to read books and magazines. Staff A called Tenant #5's family member regarding the fall and the family member declined to send Tenant #5 to the hospital. Staff A received permission from the Nurse to give Tenant #5 a Hydrocodone, per doctor's orders. Staff A got Tenant #5 ready for bed and checked in at 8:30 p.m. and Tenant #5 was asleep. About 10:30 p.m. Staff A heard Tenant #5's bed alarm and	A 013		

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went to check on him/her. Tenant #5 was in pain and she tried to elevate his/her legs to make him/her more comfortable. Tenant #5 verbalized he/she did not want to move them. Another Hydrocodone was given at 10:30 p.m. Staff A checked on Tenant #5 again at 11:30 p.m. and Tenant #5 was asleep. The Nurse arrived at 1:00 a.m. for work and she checked on Tenant #5 who then complained of pain. The Nurse sent Tenant #5 into the ER and it was determined Tenant #5 sustained a fractured right femur. An ER nurse questioned why it took so long to bring Tenant #5 into the ER and the Nurse explained the series of events. Corrective action for Staff A and Staff B on 8-10-17 included: how to assess for pain and a discussion of checking on tenants more frequently post fall (30 minute checks were advised).

Tenant #5 fell on 8-9-17 at approximately 6:30 p.m. and was transferred to the ER on 8-10-17 after 1:00 a.m. Tenant #5 was found to have a fractured femur. Post fall on 8-9-17, Tenant #5 had two pain medications administered without effective results, had complaints of pain, an abnormal presentation of the leg and was not assessed by licensed nursing staff and sent to the ER in a timely manner. Tenant #5 did not receive appropriate assessment, pain management or a prompt transfer to the ER post fall on 8-9-17. Tenant #5 did not receive services that were adequate and appropriate.

2. Record review of Tenant #6's file revealed a diagnosis of dementia. Tenant #6 was staged at a six on the GDS, which indicated severe cognitive decline.

Wound clinic documentation indicated Tenant #6 had two wounds, one on the left medial foot and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 013	Continued From page 12 one on the right proximal hip. The wound clinic documentation for 8-21-17 indicated the following information regarding the status of the wounds: The foot wound was a pressure ulcer and not healed. The stage indicated was a Stage 4 pressure injury. The measurement of the area indicated 0 x 0 x 0. The hip wound was a pressure ulcer and not healed. The stage indicated was a Stage 3 pressure injury. The measurement of the area was 0.9 x 1 x 0.3 centimeters and there was undermining. Tenant #6's weight was 85 pounds. There were wound clinic orders dated 7-31-17, 8-14-17 and 8-21-17: On 7-31-17 the orders for the foot wound indicated to cleanse wound and periwound with non-cytotoxic agent (saline or wound wash), apply primary dressing of slightly moistened Puracol cover with Vaseline gauze, cover wound and secure dressing in place with Optifoam Gentle, change dressing every other day and as needed. The orders were noted on 7-31-17. On 8-14-17 the foot wound orders directed to cleanse wound and periwound with non-cytotoxic agent (saline or wound wash), cover wound and secure dressing in place with Optifoam Gentle and change dressing every other day and as needed. It was noted on 8-14-17 at 1:45 p.m. On 8-21-17 the foot wound orders indicated to cleanse wound and periwound with non-cytotoxic agent (saline or wound wash), cover wound and secure dressing in place with Optifoam Gentle and change dressing every other day and as needed. The orders were noted on 8-21-17 at 6:52 p.m.	A 013		

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A 013	Continued From page 13 The treatment record for August 2017 directed, for the foot wound, to cleanse the left bunion with saline and apply moistened Hydrofer Blue. Then to apply Optifoam gentle covering. The treatment record did not indicate the correct dressing changes or frequency of the change. Staff documented the completion of the task of the foot wound care; however, the wound care provided was not consistent with wound care ordered. Tenant #6 did not receive the appropriate wound care to the left foot. On 7-31-17 the orders for the hip wound indicated to cleanse wound and periwound with non-cytotoxic agent (saline, distilled water or wound wash). Apply Santyl ointment, nickel thickness daily, cover wound and secure dressing in place with Optifoam and tape. Change dressing every day and as needed. It was noted on 7-31-17. On 8-14-17 the orders for the hip wound indicated to cleanse wound and periwound with non-cytoxic agent (saline, distilled water or wound wash). Apply Santyl ointment, nickel thickness daily, cover wound and secure dressing in place with Optifoam and tape. Change dressing every day and as needed. It was noted on 8-14-17 at 1:45 p.m. On 8-21-17 the orders for the hip wound indicated to cleanse wound and periwound with non-cytoxic agent (saline, distilled water or wound wash). Apply slightly moistened Hydrofera blue covered with Vaseline gauze, cover wound and secure dressing in place with Optifoam and tape and change dressing every other day and as needed. The orders were noted on 8-21-17 at 6:52 p.m. The treatment record for August 2017 directed to	A 013		

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A 013	Continued From page 14	A 013		

cleanse wound with saline or wound wash and cover with pad daily. On 8-14-17 it was discontinued on the treatment record and a notation was made to indicate the wound healed and should be kept covered with pad. There was no documentation for the completion of the hip wound care 8-14-17 through 8-22-17 (when the copies of the treatment record were collected), despite current doctor orders for the wound. An order to discontinue the wound care was not found and the orders for 8-14-17 indicated to continue the dressing change. Orders on 8-21-17 also indicated to complete a dressing change. Both orders on 8-14-17 and 8-21-17 were noted by a nurse. The completion of the dressing change as ordered was not completed and it was discontinued on the treatment record without an order. Prior to the discontinuation of the wound care on the treatment record staff documented the completion of the task of the hip wound care; however, the wound care that provided was not consistent with wound care ordered.

An interview with the Wellness Director on 8-23-17 at 11:30 a.m. indicated a former direct care staff (non-licensed staff) attended wound clinic appointments with Tenant #6 had written the orders on the treatment record and had discontinued the wound care order.

Tenant #6 did not receive wound care as doctor ordered for both wounds. Tenant #6 did not receive services that were adequate and appropriate.

3. Record review of Tenant #7's revealed diagnoses included: dementia, bi-polar and depression. Tenant #7 was staged at a six on the GDS, which indicated severe cognitive decline.

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A 013	Continued From page 15 According to a doctor order, dated 8-12-17, Tenant #7 should receive Diazepam 2 mg, one tablet every eight hours as needed for anxiety and agitation. The August 2017 medication administration record (MAR) reflected Diazepam 2 mg tablet, one tablet every eight hours as needed; however, it was indicated at 8:00 a.m. and 4:00 p.m. and staff initialed the administration of the medication twice daily at those times from 8-12-17 to 8-23-17. The PRN Medication Information document reflected the medication was as needed; however, staff documented the reason the medication was given was that it was scheduled. Only twice was it documented the medication was given for agitation as ordered. It was transcribed on the MAR as needed; however, the frequency listed was scheduled twice daily. Staff administered it as it was scheduled and only twice was the medication administered at the frequency and reason the medication was ordered. Tenant #7 did not receive services that were adequate and appropriate.	A 013		
{A 094}	481-67.13(4) Exit Interview, Final Report and POC 481-67.13(17A,231C,85GA,SF394) Exit interview, final report, plan of correction. 67.13(4) Monitoring revisit. The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. The department may issue a regulatory insufficiency for failure to implement the plan of correction. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance.	{A 094}		

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{A 094}	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on record review the Program failed to implement the Plan of Correction effective 6-1-17. Findings follow: A review of the Plan of Correction indicated the plan was not implemented or completed by effective date of 6-1-17 in the areas of program policies and procedures and service plans. Please see 67.2(1)(d) and 69.26 (4)(a) for additional information.	{A 094}		
A 040	481-69.23(1)c(1) Criteria for Admission/Retention of Tenants 481-69.23(231C) Criteria for admission and retention of tenants. 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently comply with admission and retention requirements of tenants as evidenced by retention of a chronically sexually aggressive tenant. This pertained to 1 of 5 tenants reviewed (Tenant #7). Findings follow:	A 040		

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A 040	Continued From page 17 Record review revealed Tenant #7's Nurse's Notes indicated the following: a. On 6-1-17 Tenant #7 encouraged tenants of the opposite sex to sit next to him/her. Tenant #7 held their hands and eventually put the individual's hand down his/her own pants. Nurse's Notes indicated it was a "constant task" to keep him/her from luring tenants of the opposite sex to the sofa or to his/her apartment. b. On 6-7-17 Tenant #7 had his/her hands inside another tenant's protective undergarments. The other tenant was removed and Tenant #7 taken to bathroom. Nurses notes documented Tenant #7's behaviors continued to increase in frequency. c. On 8-4-17 at 9:30 a.m. Tenant #7 touched himself/herself in front of another tenant. Staff removed Tenant #7 from the area. d. On 8-4-17 at 10:30 a.m. Tenant #7 had his/her hands inside another tenant's pants. The other tenant was removed from the area. Staff told Tenant #7 him/her his/her actions were inappropriate and Tenant #7 became very angry and combative. The Program called an ambulance, but Tenant #7 refused to go with paramedics. Tenant #7's legal representative gave permission for Tenant #7 to be sedated. The ambulance transferred Tenant #7 to the hospital. Tenant #7's legal representative informed the Program Tenant #7 would be returning to the program with an order to treat a urinary tract infection (UTI). The hospital notified the Program Tenant #7 would return to the Program, and the Program informed the hospital they were unable to take Tenant #7 back due to	A 040		

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A 040	Continued From page 18 danger to other tenants. A call was made to corporate and the corporate nurse directed the Program to not allow Tenant #7 to return. Nurse's Notes indicated Tenant #7's legal representative "insisted" Tenant #7 return. Tenant #7 did return on 8-4-17 with new orders for Alprazolam and an antibiotic. Staff were instructed to make rounds every 15 minutes during the night to ensure Tenant #7 slept. e. On 8-12-17 Nurse's Notes indicated Tenant #7 acted out sexually towards another tenant. Staff removed the other tenant from the area and Tenant #7 became aggressive towards staff. Tenant #7 stated he/she would break the staff's arm and chased staff down the hall yelling profanities at staff, who escaped out the door. f. On 8-12-17 the doctor ordered diazepam 2 milligram (mg) by mouth every eight hours as needed. The doctor also directed if the tenant harmed staff or was aggressive to tenants, the Program should call police and file charges. g. On 8-15-17 an appointment was made for a psych evaluation on 10-25-17. h. On 8-19-17 Tenant #7 became angry with the Nurse when she removed tenants of the opposite sex from the living area. Tenant #7 became combative and attempted to hit and push her to the floor. The Nurse left the building and as needed medication was administered. i. On 8-21-17 the Nurse, Tenant #7, and Tenant #7's legal representative met with the doctor to answer questions regarding Tenant #7's sexual aggression towards tenants of the opposite sex. The doctor obtained a psychiatric consultation and advised changes would be made to the	A 040		

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A 040	Continued From page 19 tenant's medications. Continued record review revealed Tenant #7's hospital records indicated Tenant #7 seen on 8-4-17. Tenant #7 presented with psychiatric concerns and agitation and the onset was chronic. Documentation indicated Tenant #7 engaged in chronically inappropriate behaviors in the memory care where he/she resided. The Program planned to send the tenant to a psychiatric inpatient unit for evaluation of his/her chronically inappropriate sexual behaviors. Tenant #7's service plan reflected Tenant #7 had tendencies of inappropriate behavior toward certain vulnerable tenants; Tenant #7 would hold their hands and try to persuade the tenants to touch him/her inappropriately. Staff were to be aware of the tenants he/she tended to seek out and to monitor the whereabouts of Tenant #7. The plan directed Tenant #7 should not sit with tenants of the opposite sex at meals and tenants of the opposite sex were to avoid the hall where Tenant #7 resided. Additional record review revealed Tenant #7's August 2017 medication administration records (MARs) indicated medication orders including: diazepam 2 mg, one tablet by mouth every eight hours as needed; Alprazolam 0.5 mg, one tablet by mouth every eight hours as needed; Premarin 0.45 mg tablet, one tablet by mouth once daily; and Paxil 20 mg, one tablet by mouth daily. Record review of Tenant #7's file revealed diagnoses included: dementia, bi-polar and depression. Tenant #7 was staged at a six on the GDS, which indicated severe cognitive decline. When interviewed on 8-21-17 at 3:04 p.m. and	A 040		

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A 040	Continued From page 20 8-22-17 at 4:15 p.m. the Nurse stated she had been told a Tenant #7 was sexually inappropriate, but she never witnessed it. The Nurse explained Tenant #7 would "lure" tenants of the opposite sex to his/her apartment. Two weeks ago Tenant #7 after being sexually inappropriate towards another tenant, Tenant #7 chased the Nurse and was sent to the emergency room. She reported there had been another incident when Tenant #7 attempted to hit the Nurse after she removed tenants of the opposite sex away from Tenant #7. The Nurse said Tenant #7 always tried to coax a tenant of the opposite sex to his/her apartment or to the couch. Some incidents of Tenant #7's behavior included: putting his/her hands into other tenant's pants, touching himself/herself in front of another tenant, or playing with another tenant's shirt, trying to pull it up. Staff reported the behavior went on for a year or two and occurred frequently. According to the Nurse, interventions included: to keep tenants of the opposite sex away from Tenant #7, to increase estrogen to the maximum dose, an order for Valium and Paxil and a psych evaluation. The Nurse reported Tenant #7 was sexually aggressive at times, but stated he/she was safe to be there if the tenants of the opposite sex were kept away. When interviewed on 8-21-17 at 4:44 p.m. Staff B reported Tenant #7 would try to encourage a tenant of the opposite sex to come sit on the couch with him/her. He/she would put the other tenant's hands in his/her pants and Tenant #7 had put his/her hand in the other tenant's pants before, as well. Staff B reported this occurred two to three times in the past month or two. Staff B stated Staff closed the door to the another side of the building.	A 040		

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A 040	Continued From page 21 When interviewed on 8-22-17 at 4:40 p.m. Staff C reported Tenant #7 had sexual tendencies and the behaviors had been present for approximately six months. Staff C reportedly never witnessed Tenant #7's sexual behavior. Based on reports heard, Staff C described the behavior as almost "calculating," regarding the behaviors occurring on second shift as there were less staff present. Tenant #7 would walk to the other hall where a tenant lived and call the other by his/her name. Staff C described Tenant #7 as difficult to redirect and state he/she did not participate in activities. When interviewed Staff D on 8-21-17 at 12:06 p.m. Staff D reported Tenant #7 acted sexually inappropriate toward other tenants. Staff D reported Tenant #7 touched tenants of the opposite sex. When interviewed on 8-23-17 at 1:51 p.m. Staff E reported Tenant #7 sexually abusive toward another tenant. Staff E explained Tenant #7 touched the other tenant sexually. Staff E witnessed Tenant #7 touching himself/herself in the apartment. Staff E reported Tenant #7 had intense sexual behavior. When interviewed on 8-23-17 at 8:50 a.m. the Executive Director reported knowledge of Tenant #7's sexual desires. She felt they could have done better helping Tenant #7 manage these urges. The Executive Director stated interventions for the behavior included having tenants of the opposite sex in a different hall, which everyone agreed upon. The Executive Director stated previously the primary care physician had not been made aware of the behavior. With the doctor involved there had been medication changes including the addition of an antidepressant to reduce libido and	A 040		

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A 040	Continued From page 22 medication changes with Estrogen and Valium. The Executive Director explained Tenant #7's directed his/her behavior towards other tenants, but there had been no injuries. The Executive Director stated the Program needed to give Tenant #7 a chance with the medication changes.	A 040		
A 045	481-69.23(1)g Criteria for Admission/Retention of Tenants 481-69.23(231C) Criteria for admission and retention of tenants. 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: g. Has unmanageable incontinence on a routine basis despite an individualized toileting program This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to consistently comply with admission and retention requirements of tenants as evidenced by retention of a tenant with unmanageable incontinence. This pertained to 1 of 5 tenants reviewed (Tenant #6). Observation on 8-22-17 at 3:30 p.m. revealed Staff B transferred Tenant #6 from the wheelchair to his/her bed. Tenant #6 did not bear weight or participate with the transfer. Tenant #6's legs were contracted when lifted by staff, and remained contracted once placed on the bed. Staff B prepared to check Tenant #6's protective undergarment in bed and did not take Tenant #6 to the bathroom. Staff B verbalized the protective undergarment was not wet and Tenant #6 was not changed. Staff B transferred Tenant #6 back	A 045		

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A 045	Continued From page 23	A 045		

from the bed to the wheelchair and Tenant #6 did not bear any weight and was cradled to transfer back into the wheelchair. Tenant #6's legs were again contracted.

Record review of Tenant #6's file revealed a diagnosis of dementia. Tenant #6 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. The service plan reflected Tenant #6 needed to be taken to the bathroom every two hours while awake for bladder incontinence and once in the night. An evaluation dated 6-17-17 indicated Tenant #6 was incontinent of bladder and wore protective undergarments at all times.

An interview with Staff A on 8-21-17 at approximately 2:25 p.m. revealed Tenant #6 required two staff to take him/her to the toilet. Tenant #6 did not assist with toileting. Staff checked Tenant #6 every two hours.

An interview with Staff B on 8-21-17 at 4:44 p.m. revealed Tenant #6 could not do anything himself/herself except to eat. Toileting was completed in bed as Tenant #6 could not stand and staff rolled him/her in bed. Tenant #6 did not help with toileting.

An interview with Staff D on 8-21-17 at 12:06 p.m. revealed Tenant #6 was unmanageably incontinent and two staff were needed to toilet Tenant #6.

An interview with Staff F on 8-21-17 at 5:55 p.m. revealed Tenant #6's protective undergarment was usually changed in bed and Tenant #6 did not go on the toilet or commode.

An interview with Staff G on 8-22-17 at 2:02 p.m.

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A 045	Continued From page 24 revealed Tenant #6 was usually changed in bed and no staff took him/her to the toilet. Tenant #6 would not hold the bar and did not help with toileting. An interview with the Nurse on 8-21-17 at 3:04 p.m. revealed Tenant #6 was total care. The Nurse could not move him/her and she needed two staff to transfer Tenant #6. She said Tenant #6 would grab the bar but could not verbalize he/she needed to go to the bathroom.	A 045		
{A 089}	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to develop service plans to reflect identified needs of tenants. This pertained to 2 of 5 tenants reviewed (Tenants #6 and #7). Findings follow: 1. Observation on 8-22-17 at 3:30 p.m. revealed Staff B transferred Tenant #6 from the wheelchair to his/her bed. Tenant #6 did not bear weight or participate with the transfer. Tenant #6's legs were contracted when lifted by staff, and remained contracted once placed on the bed.	{A 089}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 089}	Continued From page 25 Staff B prepared to check Tenant #6's protective undergarment in bed and did not take Tenant #6 to the bathroom. Staff B verbalized the protective undergarment was not wet and Tenant #6 was not changed. Staff B transferred Tenant #6 back from the bed to the wheelchair and Tenant #6 did not bear any weight and was cradled to transfer back into the wheelchair. Tenant #6's legs were again contracted. Record review revealed Tenant #6's service plan indicated he/she needed to be taken to the bathroom every two hours while awake for bladder incontinence and taken once in the night. The service plan reflected Tenant #6 was a one person transfer and required assistance from bed to chair and vice versa. An interview with Staff B on 8-21-17 at 4:44 p.m. revealed Tenant #6 could not do anything himself/herself, except eat. Toileting was completed in bed as Tenant #6 could not stand and staff rolled him/her in bed. Tenant #6 did not help with toileting. An interview with Staff F on 8-21-17 at 5:55 p.m. revealed Tenant #6's protective undergarment was usually changed in bed and Tenant #6 did not go on the toilet or commode. An interview with Staff G on 8-22-17 at 2:02 p.m. revealed Tenant #6 was usually changed in bed and no staff took him/her to the toilet. Tenant #6 would not hold the bar and did not help with toileting. Further review of Tenant #6's service plan revealed it did not reflect staff changed Tenant #6 in bed for toileting needs and also did not accurately reflect the transfer process for Tenant	{A 089}		

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{A 089}	Continued From page 26 #6. b. Continued record review revealed a 90 day nurse review, dated 5-5-17, indicated Tenant #6 was on a turn schedule at night related to bony structure and wore hip pads at night. Review of the service plan revealed failure reflect the need for repositioning at night or the hip pads worn at night. c. Further record review indicated wound clinic documentation indicated orders including: to increase the nutritional supplement to two to three times per day, mattress overlay/speciality bed or mattress and wheelchair cushion. Review of the service plan revealed failure to reflect the nutritional supplement, mattress overlay or wheelchair cushion. The service plan did not reflect the identified needs of Tenant #6. 2. Record review of Tenant #7's file revealed his/her nurses notes indicated the following: a. On 6-1-17 it was noted Tenant #7 encouraged tenants of the opposite sex to sit next to him/her. He/She would hold their hands and eventually put their hand down his/her pants. Nurse's Notes indicated it was a "constant task" to keep him/her from luring tenants of the opposite sex to the sofa or to his/her apartment. b. On 6-7-17 Tenant #7 had his/her hands inside another tenant's protective undergarments. The other tenant was removed and Tenant #7 taken to bathroom. It was noted Tenant #7's behavior was occurring more frequently. c. On 8-4-17 at 9:30 a.m. Tenant #7 touched	{A 089}		

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{A 089}	Continued From page 27 himself/herself in front of another tenant. Tenant #7 was removed from the area. d. On 8-4-17 at 10:30 a.m. Tenant #7 had his/her hands inside another tenant's pants. The other tenant was removed from the area and Tenant #7 was told his/her actions were inappropriate. Tenant #7 became angry and combative. An ambulance was called. Tenant #7 refused to go with paramedics and permission was given by the legal representative to have Tenant #7 sedated. Tenant #7 was transferred to the hospital. Tenant #7's legal representative called and said Tenant #7 would be returning to the program with an order to treat a urinary tract infection (UTI). A call was received from the hospital which indicated Tenant #7 would be returned to the Program and the hospital was told the Program was unable to take Tenant #7 back due to danger to other tenants. A call was made to corporate and the corporate nurse instructed the Program not to take Tenant #7 back. Nurse's Notes indicated Tenant #7's legal representative "insisted" Tenant #7 return. Tenant #7 returned on 8-4-17 with new orders for Alprazolam and an antibiotic. Staff were instructed to make rounds every 15 minutes during the night to ensure Tenant #7 slept. e. On 8-12-17 Tenant #7 acted out sexually towards another tenant. The other tenant was removed from the area and Tenant #7 became aggressive towards staff. Tenant #7 stated he/she would break the staff's arm and chased staff down the hall yelling profanities at staff, who escaped out the door. f. On 8-19-17 Tenant #7 became very angry with the Nurse when she removed tenants of the	{A 089}		

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{A 089}	Continued From page 28 opposite sex from the living area. Tenant #7 became combative and tried to hit and push her to the floor. The Nurse left the building and as needed medication was administered. Continued record review revealed Tenant #7's service plan indicated Tenant #7 had tendencies of inappropriate behavior toward certain vulnerable tenants. Tenant #7 would hold their hands and try to persuade the tenants to touch him/her inappropriately. The Service Plan directed staff to be aware of the tenants he/she tended to seek out and to monitor the whereabouts of Tenant #7. Tenant #7 should not to sit with the tenants of the opposite sex at meals and the tenants of the opposite sex were to not be kept in the hall that Tenant #7 resided. Tenant #7's service plan failed to reflect the combative behavior that resulted at times when Tenant #7 was redirected and the other tenants were removed and interventions related to the behavior.	{A 089}		
A 096	481-69.27(1)c Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 69.27(1)c To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's	A 096		

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A 096	Continued From page 29 health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse reviews as warranted by significant change in tenants' health status. This affected 3 of 5 tenants reviewed (Tenants #3, #5 and #6). Findings follow: 1. Record review revealed incident reports completed by Staff A, on 8-9-17 at 6:30 p.m. Tenant #5 got out of his/her wheelchair and tried to walk. As the alarm went staff ran to grab him/her and Tenant #5 hit the floor before staff could catch him/her. Tenant #5 landed on his/her right leg and held his/her knee. Staff A further documented she and a co-worker got Tenant #5 back in his/her chair and to the dining room table. Staff A took his/her vitals (temperature was 97.3, respirations were 18, pulse was 65 and blood pressure was 144/85) and a pain medication was given. Tenant #5 began reading a book and calmed down. Staff checked the length of Tenant #5's legs and made sure his/her hip was in place, which it was. At that time he/she started saying he/she was in pain so staff took him/her to bed so that he/she could relax. About 10:30 p.m. his/her alarm went off. Tenant #5 was in pain and staff tried to elevate his/her legs but Tenant #5 did not want the pillow placed. Staff A went and got a co-worker because the way Tenant #5 was laying seemed strange. Tenant #5 screamed, "like in more pain." Staff waited for the Nurse to get there before assisting further to verify the position of the legs. When the Nurse arrived Staff A told her Tenant #5 should be sent out because he/she	A 096		

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could not take the pain and Tenant #5 was sent out. According to the incident report, staff initially notified the nurse of the fall on 8-9-17 at 6:37 p.m.

An incident reported completed by Staff B dated 8-9-17 indicated at about 6:40 p.m. Staff B responded to assist Staff A with lifting Tenant #5 from lying on the floor. Tenant #5 was able to sit in the wheelchair. At about 7:30 p.m. Staff A requested to put Tenant #5 in bed. Both of Tenant #5's legs were stretched out. At 11:06 p.m. Staff A told Staff B that Tenant #5 was in pain and his/her leg "bends."

Record review of Tenant #5's file revealed diagnoses included: dementia, osteoporosis, degenerative joint disease and status/post compression fracture (thoracic). Tenant #5 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. The service plan reflected Tenant #5 required a chair alarm when in the chair and under him/her when in bed. Tenant #5 was independent with mobility inside the building by propelling the wheelchair and was dependent outside of the building. Tenant #5 had physical therapy (PT); however, it was discontinued on 8-9-17. Nurse's Notes dated 6-5-17 to 7-10-17 indicated Tenant #5 was admitted to the hospital for a broken hip, had surgical repair, went to a skilled facility and returned on 7-10-17.

Nurse's Notes dated 8-17-17 (late entry) indicated staff called the Nurse on 8-9-17 at 6:30 p.m. to report Tenant #5 fell to the floor in the living room. Staff were instructed to check for leg length and if the legs were even and check range of motion and any complaints of pain with movement. Tenant #5's family was called and said not to

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send to the emergency room (ER). Staff were instructed to stand Tenant #5 and to place in the wheelchair following hip precautions. Staff stated Tenant #5 transferred without incident or complaints of pain. Staff were instructed the Nurse would be in the building at 12:45 a.m. to work the night shift and to call if further complaints of pain. At 12:00 a.m. staff called the Nurse and stated Tenant #5 complained of pain and staff were instructed to give a pain pill and the Nurse was on her way to the program. At 12:45 a.m. the Nurse arrived at the building and assessed Tenant #5. The right leg was twisted under Tenant #5 and the left leg was pulled up to the chest. Staff were instructed to call an ambulance. Paramedics arrived and transferred Tenant #5 to the ER and Tenant #5's family was called again without success. At 2:00 a.m. a call was received from the hospital which indicated Tenant #5's femur was broken.

According to a PRN Medication Information document, the following was ordered: Hydrocodone/Acetaminophen 5/325 milligram (mg), one tablet, every four hours as needed for pain and Lorazepam 0.5 mg, one tablet, every four hours as needed for agitation. On 8-9-17 at 6:30 p.m. one tablet of Lorazepam was administered and the result as of 7:30 p.m. was effective. On 8-9-17 at 6:40 p.m. one tablet of Hydrocodone/Acetaminophen was administered for pain and the result as of 7:20 p.m. was not effective. On 8-9-17 at 10:30 p.m. one tablet of Hydrocodone/Acetaminophen was administered for pain and the result as of 1:00 a.m. was not effective.

Emergency medical services records indicated the call was received on 8-10-17 at 12:53 a.m. and medics arrived at the building at 1:02 a.m.

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A 096	Continued From page 32 Medics were dispatched for a fall with hip pain. Staff reported Tenant #5 fell that afternoon on his/her hip. At that time Tenant #5 had not expressed any complaints and staff put Tenant #5 back into the wheelchair and later to bed. Staff reported after Tenant #5 was in bed he/she started having complaints of pain and they found him/her with a deformed right leg. It was noted Tenant #5 had an obvious deformity to the right hip and right leg and swelling to the same areas. The right leg was externally rotated and Tenant #5 had his/her leg bent at the knee. The left knee was drawn up and there were complaints of pain when that leg was straightened out. Tenant #5 was given Fentanyl intravenous push with improvement in his/her complaints of pain. Tenant #5 was transported to the hospital. Hospital records indicated Tenant #5 was seen on 8-10-17 at 1:55 a.m. due to falling while getting out of wheelchair. The records documented the tenant was to put to bed and woke up screaming with an obvious deformity to the right hip with shortening and rotation. Symptoms included: pain, swelling and loss of mobility and the degree at present was severe. Diagnostic Radiology records indicated the impression was an acute fracture of the right femoral diaphysis with displacement/angulation. The discharge summary indicated the date of admission was 8-10-17 to 8-16-17. Discharge diagnosis indicated closed femur fracture, status/post open reduction and internal fixation of a closed periprosthetic femur fracture from a fall. Tenant #5 could not bear weight for eight weeks post surgery. The discharge summary indicated Tenant #5 was seated in a chair, tried to get up and suddenly fell. He/she was helped back to the chair but leg deformity was noted. Tenant #5 was brought to the hospital where he/she was	A 096		

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diagnosed with a right hip fracture. Family decided to have surgical repair and Tenant #5 had an open reduction and internal fixation of the right femoral shaft fracture with bone grafting for the right periprosthetic closed femur fracture.

An interview with Staff A on 8-21-17 at approximately 2:25 p.m. revealed Tenant #5's family brought him/her to the living room and asked Staff A to let the family member out of the building. Staff A went to get Staff B when Tenant #5's alarm went off and Staff A responded. Tenant #5 was lying on his/her right side in the living room. Staff A called the Nurse and Staff B stayed with Tenant #5. The Nurse instructed staff to check vital signs and to ensure Tenant #5's legs were even. Tenant #5 complained of knee pain and Staff A administered an as needed pain pill. There was nothing abnormal with vitals and Staff A and Staff B transferred Tenant #5 off the ground to the wheelchair. Tenant #5's family was notified and declined to send Tenant #5 out to the hospital. Once in the chair staff observed his/her legs and there were no other complaints voiced. Staff A and Staff B helped get Tenant #5 get dressed and ready for bed. Tenant #5 was relieved to lay down. The bed alarm would go off and Tenant #5 was close to the edge of the bed and was moved using the underpad. Staff A completed rounds and pulled back the covers and noticed the right leg looked funny and Tenant #5 grimaced. There was a dramatic change at 10:00 p.m./10:30 p.m. Staff A went and got Staff B as the leg did not look normal. The Nurse was called; she was coming in and directed them to give Tenant #5 another pain pill until she got there. Tenant #5 seemed like he/she was in pain. As soon as the Nurse arrived the non-emergency ambulance was called.

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A 096	Continued From page 34 An interview with Staff B on 8-21-17 at 4:44 p.m. Staff B cleaned up after supper and Tenant #5 was in the living room. Staff A was the caregiver for the area where Tenant #5 resided. Staff A had just come in the dining room and sat down and Tenant #5's chair alarm went off. Staff A got up and Tenant #5 was on the floor. Tenant #5's family had just left. Tenant #5 was laying on the floor on his/her right side. There was no response when asked if there was any pain. Tenant #5 was picked up and put into the wheelchair. Staff A pushed Tenant #5 into the dining room and gave him/her a magazine. Tenant #5 could stand up when he/she was placed in the wheelchair and voiced no complaints of pain. Staff A and Staff B changed Tenant #5 into pajamas. Tenant #5 stood up when staff assisted Tenant #5 with getting changed for bed around 7:00 p.m. to 8:00 p.m. When Staff A and Staff B put Tenant #5 into bed his/her legs were straight. Close to 11:00 p.m. Tenant #5 was in pain and Staff A asked Staff B to look at Tenant #5's leg. It was different, the leg was bent in the opposite direction, it looked "like something out of the Exorcist." Tenant #5's leg was not like that before. As soon at the Nurse arrived she went in to check Tenant #5. Interviews with the Nurse on 8-21-17 at 3:04 p.m. and 8-22-17 at 4:15 p.m. revealed she worked on the floor the day of Tenant #5's fall. She received a telephone call from Staff A at 6:30 p.m. Staff A reported Tenant #5's family had just left and Staff A had gone into the other room and heard the chair alarm. Tenant #5 fell on his/her hip on the right side. There were no issues with shortening of legs and no complaints of pain. Staff B assisted Staff A with picking Tenant #5 up off the ground. Tenant #5 was weight bearing and had no complaints. Tenant #5 sat in the wheelchair in	A 096		

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the dining room. Staff A and Staff B said Tenant #5's legs were straight. Something happened in bed and during rounds staff heard Tenant #5 moaning. Around 11:45 p.m. to 12:00 a.m. she received a telephone call from staff regarding Tenant #5 and she was on her way into the building. When the Nurse arrived Staff A asked her to check Tenant #5's legs. Tenant #5's leg was twisted and a non-emergency ambulance was called. Tenant #5 was diagnosed with a femur fracture and needed surgery. A nurse at the hospital asked how Tenant #5 was left in that condition. The Nurse explained range of motion was completed and the leg was not deformed until 11:00 p.m. rounds. She was not informed the leg looked different until she arrived, staff had called the second time to administer a pain pill.

A written statement from the Executive Director dated 8-10-17 indicated she arrived at the Program at 4:50 a.m. on 8-10-17 and received a report from the Nurse that Tenant #5 was sent to the hospital with a possible fracture. She called and spoke with Staff A, who reported Tenant #5 had been seated in the wheelchair and had spent time with his/her family in the living area. The family member had just left the building and Staff A walked into the dining room, a few feet from where Tenant #5 was located and she heard Tenant #5's chair alarm going off. Staff A ran towards Tenant #5, who was already falling to the floor. Staff A called the Nurse and gave a verbal report which indicated the fall occurred on the right side. Staff A verbalized Tenant #5's legs were even. There was no evidence of pain, other than Tenant #5's knee hurt a little bit. Staff A and Staff B assisted Tenant #5 back into the wheelchair and Staff A assisted Tenant #5 into the dining room to read books and magazines. Staff A called Tenant #5's family member regarding the

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fall and the family member declined to send Tenant #5 to the hospital. Staff A received permission from the Nurse to give Tenant #5 a Hydrocodone, per doctor's orders. Staff A got Tenant #5 ready for bed and checked in at 8:30 p.m. and Tenant #5 was asleep. About 10:30 p.m. Staff A heard Tenant #5's bed alarm and went to check on him/her. Tenant #5 was in pain and she tried to elevate his/her legs to make him/her more comfortable. Tenant #5 verbalized he/she did not want to move them. Another Hydrocodone was given at 10:30 p.m. Staff A checked on Tenant #5 again at 11:30 p.m. and Tenant #5 was asleep. The Nurse arrived at 1:00 a.m. for work and she checked on Tenant #5 who then complained of pain. The Nurse sent Tenant #5 into the ER and it was determined Tenant #5 sustained a fractured right femur. An ER nurse questioned why it took so long to bring Tenant #5 into the ER and the Nurse explained the series of events. Corrective action for Staff A and Staff B on 8-10-17 included: how to assess for pain and a discussion of checking on tenants more frequently post fall (30 minute checks were advised).

Tenant #5 fell on 8-9-17 at approximately 6:30 p.m. and was transferred to the ER on 8-10-17 after 1:00 a.m. Tenant #5 was found to have a fractured femur. Tenant #5 had two pain medications administered without effective results, had complaints of pain, an abnormal presentation of the leg and an assessment was not completed by licensed nursing staff until approximately 12:45 a.m. A nurse review was not completed at the time of fall with injury for Tenant #5. A late entry was documented on 8-17-17, eight days after the initial fall and two days after an onsite investigation was initiated by the Department. A nurse review was not completed

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	S0017	A. BUILDING: _____ B. WING _____	R-C 09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR	900 W 46TH ST DAVENPORT, IA 52806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 096	Continued From page 37 as needed for Tenant #5. When interviewed on 8-21-17 at 3:04 p.m. the Nurse indicated a late entry was completed for the nurse review for Tenant #5 because the Executive Director had the information to complete the self-report to the Department. The Nurse also indicated she had time off after the incident. 2. Record review of Tenant #6's file revealed Nurse's Notes dated 6-17-17 indicated Tenant #6 had a urinary tract infection (UTI) and Macrobid 100 mg, one tablet by mouth, twice daily for seven days was ordered. Continued record review revealed no nurse review. 3. Record review of Tenant #3's file revealed Nurse's Notes, dated 5-25-17, documented Tenant #3 ambulated about and had a harsh cough. On 5-26-17 Nurse's Notes indicated a new order received for Robitussin DM, two teaspoons every four to six hours as needed for a cough. Continued record review revealed the last entry in Nurse's Notes occurred 5-26-17. A nurse review could not be located to follow up on the cough and ordered treatment.	A 096		

OK 10/19/17

COUNTRY MANOR
MEMORY CARE

October 11, 2017

Complaint/Incident Intake:
Second Revisit of Investigation #64658-I and Investigation of Incidents #68237-I, 70048-I, and Complaint #70171-C

Iowa Department of Inspection & Appeals
Program Coordinator
Adult Services Bureau
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

To Whom It May Concern,

Please consider this our plan of correction for the regulatory insufficiencies cited during August 15, 2017 – September 12, 2017, with the **Final Complaint/ Incident Investigation, Country Manor, Davenport, IA** completed by the Department of Inspection and Appeals (DIA) in accordance with the Code of Iowa, section 231C and Iowa Administrative Code, chapters 481-67 and 481-69, pertaining to regulatory insufficiency in the areas of incident reports, tenant rights, criteria for admissions/retention of tenants, service plans, nurse review, and failure to implement previous plan of correction.

Incident Reports

481-67.2(1)d Program Policies and Procedures
67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following:

d. The incident report shall include statements from individuals, if any, who witnessed the incident.

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. Following the results of our most recent onsite visit, along with reviewing our policies, Wellness Director and Executive Director will consult with Grace Management to address Incident Reporting Policy and Procedure, along with creating a Witness Statement form.

b. The Wellness Director or RN will ensure Incident Reports and Witness Statements will be gathered for all incidents that occur out of the ordinary.

2. What measures will be taken to ensure the problem does not recur?
    a. All Incident Reports will be reviewed by the Wellness Director or RN with the Executive Director within 24 hours or the next business day.

3. How the program plans to monitor performance to ensure compliance.
    a. Wellness Director or Nurse will meet with the Executive Director during daily meeting, or next business day, to review all Incident Reports and Witness Statements to ensure steps taken to prevent reoccurrence.

4. Date by which the regulatory insufficiency will be corrected?
    a. Reviewed Incident Reporting during Mandatory In-Service on September 22, 2017.
    b. Following the results of our most recent onsite visit and reviewing our policies, Wellness Director and Executive Director will consult with Grace Management to address Incident Reporting Policy and Procedure, along with Witness Statement form by October 28, 2017.
    c. A follow-up Mandatory In-Service will be hosted on or before October 28, 2017 to review the updated Incident Report policy with the team. Additionally, we will review the new Witness Statement form. All team members will be given a copy of the policy.

Tenant Rights

481-67.3 Tenant rights. All tenants have the following rights:

67.3(2) To receive care, treatment and services which are adequate and appropriate.

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. The Resident Associate team will not update MARs or TARs. This will only be completed by the Wellness Director or RN and will be updated based on Doctor's Order.
    b. All assessments will be deferred to Wellness Director or RN.
    c. Reviewing our policies, the Wellness Director and Executive Director will consult with Grace Management to address Fall Policy and Procedure.

2. What measures will be taken to ensure the problem does not recur?
    a. MARs and TARs will be reviewed by the Wellness Director or RN weekly.
    b. The Program is also looking into implementing Electronic MARs and TARs to ensure the Resident Associate team is not making changes.

3. How the program plans to monitor performance to ensure compliance.
    a. MARs and TARs will be reviewed weekly by the Wellness Director or RN.

4. Date by which the regulatory insufficiency will be corrected?
    a. Weekly review of MARs and TARs will be completed by October 28, 2017.
    b. A follow-up Mandatory In-Service will be hosted on or before October 28, 2017 to educate the Resident Associate team on medication administration.
    c. Due to having a new Wellness Director, the Resident Associate team will be re-delegated by October 28, 2017.

Criteria for Admission/Retention of Tenants

481-69.23(231C) Criteria for admission and retention of tenants.

69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who:

c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who:

(1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression

g. Has unmanageable incontinence on a routine basis despite an individualized toileting program

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. Program applied for and was approved for waiver to care for Tenant #6.
    b. Program met with family and sent Tenant #7 to VA in-patient hospital for treatment. Within days of return, Tenant #7 exhibited similar behaviors and was issued an involuntary 30-day discharge.

2. What measures will be taken to ensure the problem does not recur?
    a. Along with hospice, program will continue to monitor care of Tenant #6.
    b. Program will continue to keep Tenant #7 in visible sight, monitor any changes, and follow-up with family and doctor until discharge.

3. How the program plans to monitor performance to ensure compliance.
    a. Hospice communicates with the program after every visit. The program and hospice will make any necessary family calls regarding Tenant #6's health.
    b. A follow-up family meeting will be held on 10-13-17 to discuss next steps with next plan of care for Tenant #7. Final discharge date is October 27, 2017.

4. Date by which the regulatory insufficiency will be corrected?
    a. Final discharge date for Tenant #7 is set for October 27, 2017.

Service Plans

69.26(4) The service plan shall be individualized and shall indicate, at a minimum:

a. The tenant's identified needs and preferences for assistance

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. New Wellness Director is meeting with current family members and Resident Associates to recreate and personalize our residents' service plans.
    b. New personalized service plans will be shown and signed off by the Resident Associates caring for those residents.

2. What measures will be taken to ensure the problem does not recur?
    a. The Wellness Director or RN will complete service plans as outlined in the State of Iowa regulations - every 30 days, 90 days, or significant change - and will communicate any changes to the Resident Associate team.

3. How the program plans to monitor performance to ensure compliance.
    a. The Wellness Director or RN will keep a calendar reminding of any service plans that are needed. Service plans will be completed in a timely manner.

4. Date by which the regulatory insufficiency will be corrected?
    a. All tenant service plans will be updated to identify needs and preferences for assistance, including interventions, by October 28, 2017.

Nurse Review

481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation:

69.27(1)c To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status;

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. Wellness Director or RN will complete a Nurse Review as outlined in the State of Iowa regulations and will communicate any changes to the Resident Associate team.

2. What measures will be taken to ensure the problem does not recur?
    a. Wellness Director or RN, along with Resident Associate team, will work together when there is a condition change with a resident.

3. How the program plans to monitor performance to ensure compliance.
    a. Program Wellness Director or RN will do a Nurse Review with each condition change. She will note any changes and notify appropriate parties, as needed.
    b. Wellness Director or RN will monitor the 24-hour Resident Associate report each business morning when she arrives. All Resident Associates are educated to call On-Call Nurse as needed and for emergency situations.

4. Date by which the regulatory insufficiency will be corrected?
    a. Nurse Reviews will be completed in a timely manner on or before October 28, 2017.

Plan of Correction

481-67.13 (4) The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and a regulatory insufficiency has been corrected.

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. New Program Wellness Director and new Executive Director attended training in Des Moines on August 9, 2017 regarding Iowa state regulations.
    a. Following the results of our most recent onsite visit, the Wellness Director and Executive Director have been addressing all of the above citations and have been implementing corrections. Many of these corrections have already taken place. Of those we haven't finished, they will be in place by October 28, 2017.
    b. I have also attached a draft of the Witness Statement we hope to implement by October 28, 2017.

2. What measures will be taken to ensure the problem does not recur?
    a. Wellness Director or RN and Executive Director will review policies, host mandatory in-services, host family care plan meetings, update service plans, and conduct Nurse Reviews accordingly.

3. How the program plans to monitor performance to ensure compliance.
    a. Wellness Director or RN and Executive Director will work closely together to ensure reviews and service plans are completed in a prompt and timely manner.

4. Date by which the regulatory insufficiency will be corrected?

a. Following the results of our most recent onsite visit, chart audits will be completed for Residents #3, #6, and #7 by October 28, 2017. Resident #5 has left the Program.
b. Quarterly Chart Audits for all other tenants will begin January 2018. 25% of residents will be audited during these times.

Thank you for your time and consideration in correcting these important matters. Please give me a call if any follow-up information is required. The civil penalty check was cut on October 3, 2017.

Sincerely,

Executive Director